APPENDIX G-REGISTRATION STATEMENT FORM

State Procurement Office
1151 Punchbowl Street, #230-A
Honolulu, Hawaii 96813

Instructions for the Registration Statement of Health and Human Service Provider Responsibility (Chapter 103F, HRS)

There are two requirements to register with the State Procurement Office:

1. Complete, sign and submit Form SPO-H 100A, Registration Statement of Health and Human Service Provider Responsibility. (See some quick tips about completing the form.) The completed form should be sent to the State Procurement Office, Health & Human Services Section at:
   1151 Punchbowl St., #230A
   Honolulu, HI 96813

2. Applicants must be registered and in good standing with the Hawaii Department of Commerce and Consumer Affairs (DCCA). The State Procurement Office checks good business standing with the DCCA by checking their website at **http://www.ehawaiigov.org/dcca/cogs/exe/cog.cgi**. Please check the DCCA Business Registration-Certificate of Good Standing website before submitting your Form SPO-H-100A. If you are not registered with the DCCA, you may contact the Business Registration Division of the DCCA at (808) 586-2727 or check their website at: **http://www.BusinessRegistrations.com/**.

   Exception:
   Sole Proprietorships/Individuals- Sole proprietorships are not required to register with the DCCA.

Tips About Completing Form SPO-H-100A, Registration Statement of Health and Human Service Provider Responsibility

This form is fairly self explanatory.

Item	Title	Instructions/Explanation
1	Applicant Information	The "Legal Name" is the legal name of the business entity of the private provider. For sole proprietorships it is the sole proprietors legal name. "DBA" means doing business as. Sometimes a business is known by a name other than it's legal name.
2	Contact person	This is a person who can answer any questions about the business. The contact person for a business/private provider must not be state personnel with whom you conduct business.
3	Address	The "Business Address" is where the business is physically located. The "Mailing Address" is where all mail to the business should be sent. Sometimes the addresses are

State Procurement Office
1151 Punchbowl Street, #230-A
Honolulu, Hawaii 96813

Instructions for the
Registration Statement
of Health and Human Service Provider Responsibility
(Chapter 103F, HRS)

		different.
4	Business entity	Check the appropriate business entity for your business.
5 6 7	Geographic Area, General Population, Special Population	Select all the choices that are appropriate for your business. This is for information only. Should you later decide you wish to serve a geographic area or population that you did not select, it will not keep you from competing for such contracts.
Pages 2-3		This is for your information should you compete for and be awarded a contract. The items listed (such as tax clearance and certificate of insurance) will be required at the time of the solicitation or contracting by the purchasing agency. (Check with the purchasing agency as to when they are required.) Do not send those items to the State Procurement Office. You only need to send the completed Form SPO-H-100A (3 pages) to the State Procurement Office.
Page 3	Signature	If you are applying as individual/sole proprietor complete the side marked "Individual." All other business should complete the side marked "Organizations."

Questions or comments? Contact:
Mara Smith at 808.587.4704 or mara.smith@hawaii.gov or
Corinne Higa at 808.587.4706 or corinne.y.higa@hawaii.gov.

Our website is:
http://www.spo.hawaii.gov
Click on Procurement of Health and Human Services

STATE OF HAWAII

STATE PROCUREMENT OFFICE
REGISTRATION STATEMENT
OF HEALTH AND HUMAN SERVICE PROVIDER RESPONSIBILITY
(CHAPTER 103F, HRS)

1. APPLICANT INFORMATION:

Legal Name: _____

DBA: _____

2. CONTACT PERSON FOR MATTERS INVOLVING THIS STATEMENT:

Name: _____

Title: _____

Phone: _____ Fax: _____

e-mail: _____

3. ADDRESS:

Street Address:

Mailing Address:

4. TYPE OF BUSINESS ENTITY:

- ☐ NON PROFIT CORPORATION
- ☐ FOR PROFIT CORPORATION
- ☐ LIMITED LIABILITY COMPANY
- ☐ SOLE PROPRIETORSHIP
- ☐ PARTNERSHIP

5. GEOGRAPHIC AREA(S) APPLICANT IS INTERESTED IN SERVING:

- ☐ EAST HAWAI'I
- ☐ WEST HAWAI'I
- ☐ MAUI
- ☐ MOLOKA'I
- ☐ LANA'I
- ☐ KAUA'I
- ☐ LEEWARD O'AHU
- ☐ CENTRAL O'AHU
- ☐ WINDWARD O'AHU
- ☐ HONOLULU

6. GENERAL POPULATION(S) APPLICANT IS INTERESTED IN SERVING:

- ☐ CHILDREN: 0-3 YEARS OF AGE
- ☐ CHILDREN: 3-5 YEARS OF AGE
- ☐ CHILDREN: 5-10 YEARS OF AGE
- ☐ CHILDREN: 10-12 YEARS OF AGE
- ☐ ADOLESCENTS: 12-18 YEARS OF AGE
- ☐ ADOLESCENTS AND ADULTS: 18-21 YEARS OF AGE
- ☐ ADULTS: 21-59+ YEARS OF AGE
- ☐ ELDERS: 60+ YEARS OF AGE
- ☐ FAMILIES
- ☐ OTHER _____

7. SPECIAL POPULATION(S) APPLICANT IS INTERESTED IN SERVING:

- ☐ CHILDREN WITH SPECIAL NEEDS UNDER THE AGE OF 3
- ☐ CHILDREN WITH SPECIAL NEEDS OVER THE AGE OF 3
- ☐ INCARCERATED YOUTH
- ☐ ADJUDICATED YOUTH RESIDING IN THE COMMUNITY
- ☐ CHILDREN AND ADOLESCENTS IN NEED OF MENTAL HEALTH SERVICES
- ☐ CHILDREN WHO HAVE BEEN HARMED OR ARE THREATENED WITH HARM AND THEIR FAMILIES
- ☐ SERIOUSLY MENTALLY ILL ADULTS
- ☐ PERSONS WITH DEVELOPMENTAL DISABILITIES/MENTAL RETARDATION
- ☐ INCARCERATED ADULTS
- ☐ ADULTS UNDER THE SUPERVISION OF THE COURTS
- ☐ DEPENDANT OR DISABLED ADULTS OVER THE AGE OF 18
- ☐ IMMIGRANTS/REFUGEES
- ☐ OTHER _____

STATE PROCUREMENT OFFICE

REGISTRATION STATEMENT
OF HEALTH AND HUMAN SERVICE PROVIDER RESPONSIBILITY

(CHAPTER 103F, HRS)

WHEREAS, the undersigned provider of health and human services (the "Provider") is interested in competing for contracts awarded by the State of Hawai'i (the "State") for the provision of health and human services to Hawai'i residents, and desires to make this Registration Statement of Provider Responsibility ("Statement") in an effort to help promote greater efficiency in the competitive purchase of service procurement process pursuant to chapter 103F, HRS; and

WHEREAS, this Statement covers only general factors governing the responsibility of providers, and individual state agencies may have more or less stringent requirements for establishing the responsibility of providers;

NOW, THEREFORE, the Provider makes the following statements and representations as evidence of the Provider's responsibility, compliance with applicable law, and sound business practices:

1. Tax Clearance Certificate. The Provider has obtained, or will obtain before any award of a contract to the Provider, a tax clearance certificate for both federal and state taxes.
2. Liability Insurance. The Provider has obtained, or will obtain before any award of a contract to the Provider, liability insurance in the amount of at least one million dollars ($1,000,000).
3. Discrimination. The Provider is in compliance with all applicable federal, state, and county laws forbidding discrimination, and shall maintain such compliance throughout the term of any contract awarded to the Provider by the State.
4. Persons with Disabilities. The Provider is in compliance with all applicable federal, state, and county laws governing the treatment of persons with disabilities, and shall maintain such compliance throughout the term of any contract awarded to the Provider by the State.
5. Smoking. The Provider is in compliance with Chapter 328K, HRS, and shall maintain such compliance throughout the term of any contract awarded to the Provider by the State.
6. Drug-Free Workplace. The Provider is in compliance with the Drug Free Workplace Act of 1988, and shall maintain such compliance throughout the term of any contract awarded to the Provider by the State.
7. Licenses and Permits. The Provider has all licenses, certifications, and permits required by applicable federal, state, and county law in order to conduct the Provider's business, and shall maintain such licenses, certifications, and permits throughout the term of any contract awarded to the Provider by the State.

8. General Law. In addition to the areas specifically addressed in items 1-7 above, the Provider is in compliance with all applicable federal, state, and county law, and shall maintain such compliance throughout the term of any contract awarded to the Provider by the State.

9. Business Practices. The Provider conducts its business affairs in a professional manner that meets or exceeds the standard industry practices for similarly situated providers as to the following areas, as applicable:

   a. fiscal or accounting policies and procedures, or both;

   b. personnel policies and procedures;

   c. program policies and procedures;

   d. written policies required by applicable federal, state, or county law; and

   e. client and employee grievance policies and procedures.

10. Documentation. In the event that the Provider decides to compete for the award of a contract with the State, the Provider will cooperate with any reasonable request from the State for documents supporting this Statement.

11. Duty to Update Registration Information. Whenever there is a change to a registered Provider's status, it is the duty of the provider to update documents submitted for registration within fifteen calendar days and shall be submitted to the State Procurement Office.

The undersigned authorized representative of the Provider certifies that this statement is true and correct to the best of the Provider's knowledge.

DATED: _____ (Date), _____ (City), _____ (State)

Individuals:

_____
(Typed Name of Individual)

_____
(Signature)

_____
(Social Security Number or Federal Taxpayer ID Number)

_____
(State General Excise Tax Number)

Organizations:

_____
(Typed Name of Organization)

By: _____
(Signature)

_____
(Typed Name)

Its: _____
(Position)

_____
(Federal Taxpayer I.D. Number or EIN)

_____
(State General Excise Tax Number)

APPENDIX H-STANDARDS OF CONDUCT

APPENDIX H

PROVIDER'S
STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

"Agency" means and includes the State, the legislature and its committees, all executive departments, boards, commissions, committees, bureaus, offices; and all independent commissions and other establishments of the state government but excluding the courts.

"Controlling interest" means an interest in a business or other undertaking which is sufficient in fact to control, whether the interest is greater or less than fifty per cent (50%).

"Employee" means any nominated, appointed, or elected officer or employee of the State, including members of boards, commissions, and committees, and employees under contract to the State or of the constitutional convention, but excluding legislators, delegates to the constitutional convention, justices, and judges. (Section 84-3, HRS).

On behalf of _____, PROVIDER, the undersigned does declare as follows:

1. PROVIDER ☐ is* ☐ is not a legislator or an employee or a business in which a legislator or an employee has a controlling interest. (Section 84-15(a), HRS).

2. PROVIDER has not been represented or assisted personally in the matter by an individual who has been an employee of the agency awarding this Contract within the preceding two years and who participated while so employed in the matter with which the Contract is directly concerned. (Section 84-15(b), HRS).

3. PROVIDER has not been assisted or represented by a legislator or employee for a fee or other compensation to obtain this Contract and will not be assisted or represented by a legislator or employee for a fee or other compensation in the performance of this Contract, if the legislator or employee had been involved in the development or award of the Contract. (Section 84-14 (d), HRS).

4. PROVIDER has not been represented on matters related to this Contract, for a fee or other consideration by an individual who, within the past twelve (12) months, has been an agency employee, or in the case of the Legislature, a legislator, and participated while an employee or legislator on matters related to this Contract. (Sections 84-18(b) and (c), HRS).

---

*Reminder to agency: If the "is" block is checked and if the Contract involves goods or services of a value in excess of $10,000, the Contract may not be awarded unless the agency posts a notice of its intent to award it and files a copy of the notice with the State Ethics Commission. (Section 84-15(a), HRS).

PROVIDER understands that the Contract to which this document is attached is voidable on behalf of the STATE if this Contract was entered into in violation of any provision of chapter 84, Hawaii Revised Statutes, commonly referred to as the Code of Ethics, including the provisions which are the source of the declarations above. Additionally, any fee, compensation, gift, or profit received by any person as a result of a violation of the Code of Ethics may be recovered by the STATE.

DATED: Honolulu, Hawaii, _____.

PROVIDER

By_____
(signature)

Print Name_____

Print Title_____

Name of Provider_____

_____

Date_____

APPENDIX I-PERFORMANCE BOND

APPENDIX I

EXHIBIT B

PERFORMANCE BOND (SURETY)
(11/17/98)

KNOW TO ALL BY THESE PRESENTS:

That _____
(full legal name and street address of Contractor)

as Contractor, hereinafter called Principal, and _____

_____
(name and street address of bonding company)

as Surety, hereinafter called Surety, a corporation(s) authorized to transact business as a surety in the State of Hawaii, are held and firmly bound unto the _____
(State/County entity)

its successors and assigns, hereinafter called Obligee, in the amount of

_____
DOLLARS ($_____), to which payment Principal and Surety bind themselves, their heirs, executors, administrators, successors and assigns, jointly and severally, firmly by these presents.

WHEREAS, the above-bound Principal has entered into a Contract with Obligee dated _____, for _____
_____
_____
_____
_____
_____
hereinafter called Contract, which Contract is incorporated herein by reference and made a part hereof.

NOW THEREFORE, the condition of this obligation is such that:

If the Principal shall promptly and faithfully perform, and fully complete the Contract in strict accordance with the terms of the Contract as said Contract may be modified or amended from time to time; then this obligation shall be void; otherwise to remain in full force and effect.

Surety to this Bond hereby stipulates and agrees that no changes, extensions of time, alterations, or additions to the terms of the Contract, including the work to be performed thereunder, and the specifications or drawings accompanying same, shall in any way affect its obligation on this bond, and it does hereby waive notice of any such changes, extensions of time, alterations, or additions, and agrees that they shall become part of the Contract.

In the event of Default by the Principal, of the obligations under the Contract, then after written Notice of Default from the Obligee to the Surety and the Principal and subject to the limitation of the penal sum of this bond, Surety shall remedy the Default, or take over the work to be performed under the Contract and complete such work, or pay moneys to the Obligee in satisfaction of the surety's performance obligation on this bond.

Signed this day of _____ _____

(Seal)

_____
Name of Principal (Contractor)

*

_____
Signature

_____
Title

(Seal)

_____
Name of Surety

_____
Signature

_____
Title

*ALL SIGNATURES MUST BE ACKNOWLEDGED BY A NOTARY PUBLIC

APPENDIX I

EXHIBIT C

PERFORMANCE BOND
(11/17/98)

KNOW TO ALL BY THESE PRESENTS:

That we, _____
(full legal name and street address of Contractor)

as Contractor, hereinafter called Contractor, is held and firmly bound unto the

_____,its successors and assigns, as Obligee, hereinafter called
State/County entity)
Obligee, in the amount of _____

_____
(Dollar amount of contract)

DOLLARS ($_____), lawful money of the United States of America, for the payment of which to the said Obligee, well and truly to be made, Contractor binds itself, its heirs, executors, administrators, successors and assigns, firmly by these presents. Said amount is evidenced by:

☐ Legal tender;

☐ Share Certificate unconditionally assigned to or made payable at sight to

_____

Description _____

_____

☐ Certificate of Deposit, No. _____, dated _____, issued by

_____,

drawn on _____

a bank, savings institution or credit union insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration, payable at sight or unconditionally assigned to _____

_____

☐ Cashier's Check No. _____, dated _____, issued by

_____

drawn on _____

a bank, savings institution or credit union insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration, payable at sight or unconditionally assigned to _____

_____

☐ Teller's Check No. _____, dated _____, issued by _____, drawn on _____ a bank, savings institution or credit union insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration, payable at sight or unconditionally assigned to _____

☐ Treasurer's Check No. _____, dated _____, issued by _____ drawn on _____ a bank, savings institution or credit union insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration, payable at sight or unconditionally assigned to _____

☐ Official Check No. _____, dated _____, issued by _____ drawn on _____ a bank, savings institution or credit union insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration, payable at sight or unconditionally assigned to _____

☐ Certified Check No. _____, dated _____, accepted by a bank, savings institution or credit union insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration, payable at sight or unconditionally assigned _____

WHEREAS:

The Contractor has by written agreement dated _____ entered into a contract with Obligee for the following Project: _____ _____ _____ _____ hereinafter called Contract, which Contract is incorporated herein by reference and made a part hereof.

NOW, THEREFORE,

The condition of this obligation is such that, if Contractor shall promptly and faithfully perform the Contract in accordance with, in all respects, the stipulations, agreements, covenants and conditions of the Contract as it now exists or may be modified according to its terms, and shall deliver the Project to the Obligee, or to its successors or assigns, fully completed as in the Contract specified and free from all liens and claims and without further cost, expense or charge to the Obligee, its officers, agents, successors or assigns, free and harmless from all suits or actions of every nature and kind which may be brought for or on account of any injury or damage, direct or indirect, arising or growing out of the doing of said work or the repair or maintenance thereof or the manner of doing the same or the neglect of the Contractor or its agents or servants or the improper performance of the Contract by the Contractor or its agents or servants or from any other cause, then this obligation shall be void; otherwise it shall be and remain in full force and effect.

AND IT IS HEREBY STIPULATED AND AGREED that suit on this bond may be brought before a court of competent jurisdiction without a jury, and that the sum or sums specified in the said Contract as liquidated damages, if any, shall be forfeited to the Obligee, its successors or assigns, in the event of a breach of any, or all, or any part of, the covenants, agreements, conditions, or stipulations contained in the Contract or in this bond in accordance with the terms thereof.

The amount of this bond may be reduced by and to the extent of any payment or payments made in good faith hereunder.

Signed this day of _____ _____

(Seal)

_____
Name of Contractor

_____
Signature

_____
Title

*ALL SIGNATURES MUST BE ACKNOWLEDGED BY A NOTARY PUBLIC

APPENDIX J – GA DETERMINATION AND/OR ADRC REFERRAL FORM

STATE OF HAWAII
Department of Human Services

Benefit, Employment and Support Services Division

GA DETERMINATION AND/OR ADRC REFERRAL FORM

1. Client Name: _____ Birthdate: _____
2. Case Name: _____ Case No . _____ Client ID No. _____

PART I TO: AUTHORIZED EVALUATOR DATE:

1. FROM: Unit: _____ Worker: _____ Phone: _____
2. Documents attached:
   - ___ DHS 1270, Physical Examination Report
   - ___ DHS 1271, Psychiatric Examination Report
   - ___ DHS 1127, Medical History and Disability Statement

PART II TO: Unit _____ Worker _____ FROM: Evaluator

1. ❑ Incapacity ends _____.
   ❑ Incapacity ends _____. Refer to MQD for ADRC determination. (For DHS 1271 only.)
   ❑ Administrative Approval until _____.
   ❑ Refer to MQD for final determination. (For not incapacitated/non-compliance.)
2. Remarks: _____
3. Certification: _____ Authorized Evaluator Date

PART III TO: MQD/MSB FROM: Unit: _____ Worker: _____

1. Determination Requested: ❑ GA Incapacity ❑ GA Compliance with treatment ❑ ADRC Only
2. Documents attached:
   - ___ DHS 1270, Physical Examination Report
   - ___ DHS 1271, Psychiatric Examination Report
   - ___ Other Supporting Medical Evidence
   - ___ DHS 1127, Medical History and Disability Statement (Psychiatric-upon request only)
3. Remarks: _____

PART IV TO: Unit _____ Worker _____ FROM: MQD/MSB BOARD OR ADRC

1. GA Incapacity Determination:
   - ❑ Not Incapacitated, does not meet GA requirements.
   - ❑ Incapacitated. Revaluation required to continue GA eligibility as of _____.
2. GA Non-Compliance with Treatment.
   - ❑ Applicant refuses to accept and pursue appropriate medical treatment. Deny application.
   - ❑ Recipient failed to comply with treatment. Impose appropriate sanction.
3. ADRC Determination:
   - ❑ Not Disabled.
   - ❑ Meets SSI Disability Criteria. Refer to SSA and disenroll from QUEST Health Plan.
4. Remarks: _____
5. Certification: _____ MQD Board Member or Medical/Psychiatric Consultant Date
6. Certification: _____ ADRC Social Worker Date

APPENDIX K – PHYSICAL EVALUATION REPORT

STATE OF HAWAII
Department of Human Services

Benefit, Employment and Support Services Division

PHYSICAL EVALUATION REPORT

PLEASE MAIL COMPLETED REPORT TO:

[DHS Unit Address Stamp]

1 :o check reason for the evaluation:

1. ☐ Application ☐ Re-evaluation
2. ☐ GA category ☐ AFDC category

(IMW to check appropriate category block in Physician's statement on page 2)

(Last Name) (First) (MI) Worker:_____ Phone:_____

(Case No.) (DOB M-D-Y) M( ) F( ) Sex - Check one)

I HEREBY AUTHORIZE THE EVALUATING PHYSICIAN OR MEDICAL FACILITY TO RELEASE TO THE DEPARTMENT OF HUMAN SERVICES AND ITS DESIGNEES ANY INFORMATION RELATED TO MY PAST AND PRESENT MEDICAL CARE, INCLUDING SUBSTANCE ABUSE HISTORY AND ANY INFORMATION RELATED TO MY HIV/AIDS STATUS. I UNDERSTAND THIS INFORMATION SHALL BE USED FOR THE SOLE AND LIMITED PURPOSE OF DETERMINING DISABILITY.

(Signature Of Patient Or Guardian) (Date) (Date of Application)

PHYSICAL EVALUATION TO BE COMPLETED BY THE EVALUATOR:

DATE:_____ WT._____ HT._____ TEMP._____ PULSE_____ BLOOD PRESSURE_____

NORMAL	CHECK EACH ITEM IN APPROPRIATE COLUMN	ABNORMAL	EXPLAIN ABNORMAL FINDINGS IN DETAIL AND PROVIDE SUPPORTING MEDICAL EVIDENCE
	Head, Face, Neck, and Scalp		
	Nose, Throat, and Mouth		
	Sinuses		
	Ears - General		
	Hearing: RIGHT: LEFT:		
	Eyes		
	Vision: FAR: NEAR:		
	Lungs and Chest		
	Heart		
	Vascular System		
	Abdomen and Viscera		
	Anus and Rectum		
	Endocrine System		
	G-U System		
	Upper Extremities		
	Lower Extremities		
	Feet		
	Spine, Other Musculoskeletal		
	Identifying Body Marks, Tattoos, Scars		
	Skin, Lymphatics		
	Neurologic		
	Psychiatric		

NOSIS:

*PRIMARY:*_____

*SECONDARY:*_____

INSTRUCTIONS: CHECK THE BOXES BELOW THAT BEST DESCRIBE THE ACTIVITIES YOUR EXAMINEE IS ABLE TO PERFORM DURING A 30 HOUR (MINIMUM) WORK WEEK.

ACTIVITY	HEAVY	MEDIUM	LIGHT	SEDENTARY	NONE
ing/Carrying - Occasionally: ..ifting and/or carrying during 1/3 of an 8 hr work day)	( ) 100 lbs	( ) 50 lbs	( ) 20 lbs	( ) 10 lbs. ( ) less than 10 lbs	( ) Can not lift/ carry occasionally
Lifting /Carrying - Frequently: (Lifting and/or carrying during 1/3 to 2/3 of an 8 hr work day)	( ) 50 lbs	( ) 25 lbs	( ) 10 lbs	( ) 10 lbs ( ) less than 10 lbs	( ) Can not lift/ carry frequently
Standing /Walking: (with breaks every 2 hours during an 8 hour work day) If assistive device is medically indicated, identify type:	( ) 6 hrs	( ) 6 hrs	( ) 6 hrs	( ) 2 - 4 hrs ( ) less than 2 hrs ( ) assistive device needed	( ) Can not stand and/or walk
Sitting continuously with breaks every 2 hours during an 8 hour work day.	( ) No Restrictions		( ) 6 hrs	( ) 6 hours ( ) less than 6 hrs	( ) Can not sit continuously 2 hrs

FUNCTIONAL REQUIREMENTS: CHECK THE ACTIVITY THE EXAMINEE IS ABLE TO PERFORM:

( ) CLIMBING ( ) BALANCING ( ) STOOPING ( ) CROUCHING ( ) KNEELING ( ) CRAWLING

( ) PUSHING _____ # of pounds ( ) frequently ( ) occasionally ( ) PULLING _____ # of pounds ( ) frequently ( ) occasionally

REACHING ( ) R ( ) L FINGERING (fine manipulation) ( ) R ( ) L

FEELING ( ) R ( ) L HANDLING (gross manipulation) ( ) R ( ) L

THIS SECTION MUST BE COMPLETED BY THE EVALUATING PHYSICIAN:

BASED ON YOUR EVALUATION, DESCRIBE ANY FINDING OF PHYSICAL OR MENTAL IMPAIRMENT WHICH WOULD PREVENT THE EXAMINEE FROM WORKING 30 HOURS PER WEEK. **DO NOT LIST DIAGNOSIS ONLY.** _____

DESCRIBE ALL TREATMENT PLANS TO MAKE YOUR EXAMINEE EMPLOYABLE. IN NONE, EXPLANATION IS NEEDED. _____

LICENSED PHYSICIAN'S STATEMENT OF INCAPACITY OR DISABILITY: *Complete statements only for the category checked.*

1. ☐ **GA**
   a. Can the examinee perform either manual or sedentary work of at least 30 hours per week? ( ) YES ( ) NO
   b. If the answer to the above question is NO:
      i) Is the Incapacity/Disability expected to last for a period of more than 60 days? ( ) YES ( ) NO
      ii) Indicate date Incapacity/Disability will end _____/_____/_____ (Month / Day / Year)

2. ☐ **AFDC**
   a. Can the examinee work full time at a job usually worked in or full-time at another job for which he/she is equipped by education, training, or experience? ( ) YES ( ) NO
   b. If the answer to the above question is NO:
      i) Is the incapacity/disability expected to last for a period of more than 30 days? ( ) YES ( ) NO
      ii) Indicate date incapacity/disability will end: _____/_____/_____ (Month / Day / Year)

3. **AFDC or GA**: Does the examinee refuse or fail to pursue treatment? ( ) YES ( ) NO

_____ _____ _____

or Print Name of Licensed Physician) (Signature of Physician) (Date)

_____

(Address) (City) (State) (Zip Code) (Telephone)

APPENDIX L – MEDICAL HISTORY AND DISABILITY STATEMENT

MEDICAL HISTORY AND DISABILITY STATEMENT

Instructions: It is very important that you read and answer all questions carefully. Your responses may help to determine if you are disabled. You may ask someone such as a relative, friend, eligibility worker, or someone from the health care field to help you complete this form. If someone helps you to complete the form, the answers should, to the extent possible, be in your own words.

Name of potentially disabled individual:_____
Last Name First Name

DHS Case name:_____ DHS Case Number:_____

DHS Client ID Number:_____

***** MEDICAL / PSYCHOSOCIAL PROFILE *****

1. Describe your disability and explain the reason(s) why you are unable to work:
_____
_____
_____

2. Describe the cause of your disability (i.e. accident, injury, illness, etc):
_____
_____
_____

3. Describe all treatment(s) prescribed by any physician for your disability:
_____
_____
_____
_____

4. How often do you see your doctor for treatment? (Check one of the following blocks)

[ ] weekly [ ] several times a month [ ] monthly [ ] quarterly or more

5. List hospitalization(s) within the past two years, reason for hospitalization(s), and duration(s) of stay:_____
_____
_____
_____

6. Have you applied for social security disability benefits? Check appropriate block(s):

[ ] No
[ ] Yes Date applied for benefits:_____
[ ] My application is pending.
[ ] My application has been approved and I am currently or will soon be receiving benefits.
[ ] My application was denied. Explain reason given for denial of benefits:
_____
_____

***** EDUCATION LEVEL *****

1. Are you able to understand and communicate in English:

   [ ] Yes [ ] No

2. Education: Circle the last grade you completed

   0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

3. List any educational Degree, Diploma, Training, or Certificate received: _____

***** PREVIOUS WORK EXPERIENCE *****

1. Have you ever been employed? [ ] Yes [ ] No
   If yes, list the last job and type of work: _____

2. List the date of your last employment and reason(s) why your job was terminated: _____

****

I certify that the information I have provided to be true, accurate, and correct to the best of my knowledge.

_____ _____
Signature of Applicant/Recipient Date

_____ _____ _____
Signature of Person Applying for Applicant/Recipient Relationship Date

If applicant/recipient did not complete this form on their own, explain the reason(s) why: _____

_____ _____
Name of person who help complete form Date

****

Remarks: _____

DHS 1127 (10/94)